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ABSTRACT

The role of social support in moderating the impact of childhood sexual abuse on adult psychological adjustment was examined. Women were drawn from three clinical samples (women in treatment for alcoholism, for being battered, or for mental health treatment) and two nonclinical sources (women arrested for driving while intoxicated and a random sample). Subjects completed face-to-face interviews that included both structured and open-ended questions. Subjects also completed the Symptom Checklist-90 to assess general psychiatric symptomatology, the Janis Self-Esteem Scale to measure self-esteem, and the Trauma Symptom Checklist to measure post sexual abuse trauma and dissociation. Of the 477 subjects, 238 had been sexually abused as children. Sixty-eight percent of the women in alcoholism treatment, 62% of the battered women, and 63% of the women in mental health treatment reported being sexually abused as children compared to 21% in the driving while intoxicated group and 39% in the random sample. Sexually abused women in the nonclinical samples who perceived others' responses to be supportive exhibited more positive adult adjustment scores than did women who did not perceive others to be supportive. Psychological adjustment of the socially supported nonclinical women did not differ from that of nonclinical women who had not been abused. Among clinical women, childhood sexual abuse was associated with poorer adult adjustment; however, there was little evidence that social support ameliorated the negative effects of sexual abuse. (Author/NB)

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LONG-TERM EFFECTS OF CHILDHOOD VICTIMIZATION:

THE MODERATING IMPACT OF SOCIAL SUPPORT

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Abstract

The role of social support in moderating the impact of childhood sexual abuse on adult psychological adjustment was examined. Women were drawn from three clinical sources (women in treatment for alcoholism, for being battered, or for mental health treatment) and two nonclinical sources (women arrested for driving while intoxicated and a random sample). Sexually abused women in the nonclinical samples who perceived others' responses to be supportive exhibited more positive adult adjustment scores than women who did not perceive others to be supportive. Psychological adjustment of the socially supported nonclinical women did not differ from that of nonclinical women who had not been abused. Among clinical women, childhood sexual abuse was associated with poorer adult adjustment, however, there was little evidence that social support ameliorated the negative effects of sexual abuse.

Long-Term Effects of Childhood Sexual Abuse:
The Moderating Impact of Social Support

There has been much concern lately over the long-term impact of childhood sexual abuse. Researchers have documented numerous long-term negative effects such as dissociation, depression, anger, sleep disturbance, tension, substance abuse, low self-esteem, anxiety, somatic disorders, interpersonal problems, self-destructive/suicidal behavior, behavioral and social problems (e.g., prostitution) (Briere & Runtz, 1988; Briere, 1988; see Browne & Finkelhor, 1986 for a review). It has now been well-documented that childhood sexual abuse results in serious mental health problems, however, little research has examined the impact of specific aspects of the abuse upon specific outcomes, what John Briere (1988) calls "the second wave" of investigation. The purpose of this paper is to examine the relationship between perceived social support following the childhood sexual victimization experience and adult psychological functioning.

While on a group level women who have been sexually abused present a variety of significant mental health and behavioral problems, not all women are equally affected by the experience. Rather, several factors appear to moderate the impact of sexual abuse. Factors associated with worse adjustment include severity and length of abuse (Tsai, Feldman-Summers, & Edgar, 1979), concurrent physical abuse, bizarre sexual abuse, and multiple perpetrators (Briere, 1988). Although it has never been tested empirically, some have suggested that social support following childhood sexual abuse may moderate the impact that the abuse has on later adult functioning (MacFarlane, 1978, Downs, 1990). More specifically, social support may reduce the negative impact of the sexual abuse, while negative reactions from others may

exacerbate the negative effects. For example, case studies of women who as children had revealed sexual abuse and were told that they were fabricating, embellishing, or misinterpreting an innocent event later suffered from a variety of negative outcomes such as adolescent depression, alcoholism, social and emotional withdrawal, and dissatisfaction with their marriages (Hall, Tice, Beresford, Wooley, & Hall, 1989). Women in this sample who enlisted support following the abuse tended to fare better.

Various definitions of social support have been proposed (see Thoits, 1982). For purposes of this paper, social support will be defined as the "degree to which a person's basic social needs are gratified through interaction with others" (Kaplan, Cassel & Gore, 1977). These needs may be met through socioemotional aid, such as sympathy and understanding, or through instrumental aid, such as advice, information, or physical help. Alternatively, of course, a person's needs may not be met.

Various explanations for how social support works have also been offered. Social support may facilitate the maintenance of self-esteem (Cohen & McKay, 1984), thus encouraging the recipient to engage in adaptive coping strategies (Cobb, 1976). Alternatively, social support may affect the appraisal of an event, making it seem less stressful (Lazarus & Folkman, 1984). Supportive others may also provide tangible support such as money or aid or information that facilitates coping. For example, a friend may recognize some of the victim's symptoms and encourage her to seek treatment. This paper will not focus specifically on any one mechanism but rather, we acknowledge that social support may ameliorate the negative effects of childhood sexual abuse through any or a combination of these mechanisms.

A large body of work in the area of social support has focused on the

buffering properties of social support in coping with negative life events. According to the buffering hypothesis, people with strong social support systems should be better able to cope with stressful life events. Evidence for this hypothesis is considerable (however, see Thoits, 1982 for a critique). People who perceive positive social support report better psychological and physical adjustment to such stressful events as job loss (Gore, 1978), pregnancy and delivery (Nuckolls, Cassel, & Kaplan, 1972), and abortion (Major et al., 1990). While most studies of social support have looked at adults, social support appears to function in a similar manner for children and adolescents as well. For example, social support helps children to cope with life changes (Sandler, 1980) and leads to better birth outcomes for adolescents coping with pregnancy (Barrera, 1981; Cutrona & Troutman, 1986; Unger & Wandersman, 1985).

Early studies defined social support as network size (e.g., Eaton, 1978) or simply as the presence of a spouse or roommate (e.g., Myers, 1975). However, it appears that the valence of the support received and not just the mere presence of others is the critical variable. Many interactions with members of one's social network are negative or conflicted (Hinrichsen, Revenson, & Shinn, 1984; Revenson, Wollman, & Felton, 1983; Shinn, Lehmann, and Wong, 1984; Shumaker & Brownell, 1984). Wortman and Dunkel-Schetter (1979; Dunkel-Schetter, 1984) provide many examples of interactions with others that are damaging rather than supportive for the cancer patient. For example, a cancer patient who is prone to depression may be told to "snap out of it and cheer up" or a relative may respond to a disclosure of cancer by crying hysterically as if the patient were already dead. Victims of crime may not receive the social support they need from others, who feel a need to

understand a seemingly random event by attaching blame (Janoff-Bulman, 1985). Thus a rape victim may be asked "what were you doing there at night?", implying that she is to blame. Such callous treatment, whether intentional or not, may serve to revictimize the victim (Biaggio, Watts, & Brownell, 1990; Gottfredson, Reiser, & Tsegaye-Spates, 1987). According to Shinn et al. (1984), these negative interactions may function as additional stressors. The importance of considering the valence of social support received is underscored by recent studies showing that negative social relations explain more of the variance in coping outcomes than positive relations (Rook, 1984; Sandler & Barrera, 1984).

While supportive reactions from parents and others following childhood sexual abuse may facilitate adjustment, reactions to disclosure of sexual abuse are likely to be negative for many children. Furthermore, because children lack other coping resources that adults may have, the lack of social support for child victims may be especially harmful. For example, children cannot seek medical attention or counseling services on their own; often they can't avoid the perpetrator. Many children who disclose sexual abuse are blamed for the abuse, labelled negatively ("tramp", "damaged goods"), or simply not believed. The allegations may be too painful for adults to deal with and hence they are ignored or denied. In addition, a considerable percentage of children who are sexually abused may choose not to disclose the abuse either because of threats from the abuser ("don't tell anyone or I'll kill you"), the shame and stigma associated with the abuse, the fear that she will be blamed or not believed, or because of the unavailability of supportive others. Hence, one unexplored question is whether or not disclosing sexual abuse is more or less beneficial than disclosing the abuse and perceiving the

other person to be unsupportive. In a recent study by Major et al. (in press) comparing outcomes for women facing unwanted pregnancy, women who received social support that was less than fully positive had poorer psychological adjustment following abortion than did women who received positive support. Interestingly, the psychological adjustment of women who chose not to tell about their decision to abort did not differ from the supported group.

We predicted that supportive responses to disclosure of childhood sexual abuse would buffer women against the negative impact of the abuse. Hence, the psychological adjustment of women who found others supportive was expected to be comparable to that of women who were not sexually abused. In contrast, the adjustment of women who experienced unsupportive transactions or did not tell was expected to be significantly worse compared to women who were not abused. Further, we predicted that women who had talked to another person before 18 about their sexual abuse and perceived the other person to be supportive would show better psychological adjustment as adults than women who had talked to another person and perceived that person to be unsupportive. Predictions were less clear for those women who did not disclose their sexual abuse before 18. On the one hand, these women, like the women in the Major et al. (in press) study who didn't tell, may have felt confident of their ability to cope without assistance. It is more likely, however, that these women had felt threatened by the perpetrator, did not feel that anyone would be supportive, or felt they had no-one that they could talk to. Hence, women who did not disclose their sexual abuse are more likely to show poor psychological adjustment as adults relative to those who received support.

Method

Subjects

Women between 18 and 45 who participated in a larger study on family violence and alcohol use were included in the sample. Women were recruited from clinical and nonclinical samples. The clinical samples consisted of 98 women in outpatient alcoholism treatment, 78 women in mental health treatment, and 98 women receiving services for family violence. Nonclinical samples included 103 women in a drinking driver education program following arrest for driving while intoxicated, and a random sample of 100 women from the community. The average age of the participants was 32.

Alcoholic women were currently receiving treatment for alcoholism through one of six clinics in Erie County. They were recruited at the clinics either through personal contact by one of the interviewers or through flyers which were given to eligible women by their counselors. No minimum length of sobriety was set by the study design for alcoholic women; however, individual clinics set times ranging from 6 weeks to 6 months as the minimum length of sobriety before they would allow access to their clients.

The majority of the battered women (77%) were recruited during their stay at a shelter for battered women through personal contact with one of the interviewers during one of the house meetings. The remainder were receiving counseling services for battered women at an agency affiliated with the shelter. They were either given flyers by their counselors or contacted by an interviewer before the start of their group counseling session.

Women in mental health treatment at six different clinics in Erie County were recruited through flyers which were given to them by their counselors. Women who were either actively psychotic or suicidally depressed were excluded. In the first instance, actively psychotic women were not expected to be able to provide reliable data for the study. In the second instance,

the exclusion was based upon the concern for the women; the interview dealt with extremely sensitive issues and there was concern that the interview process might contribute to negative consequences for the women.

The DWI sample consisted of women who had been arrested for driving while intoxicated and chose to attend a series of 7 drinking driver education classes in order to maintain a conditional license. Women arrested for DWI who chose to have their license suspended or who had been arrested more than once in the past 5 years for DWI did not participate in the classes. One of the interviewers described the study at the end of one of the classes and offered women the chance to participate. Although these women experienced an intervention involving their drinking, they were not seeking treatment and hence are considered a nonclinical sample.

The random sample was recruited through random digit dialing in the Buffalo area. If there was a woman in the household between the ages of 18 and 45 the study was described briefly to her and participation was solicited. Out of a total of 331 contacts with a woman 18-45 living at the residence, 34% refused before hearing the description of the study, another 29% refused after hearing about the study, 7% agreed to be interviewed but failed to establish or keep appointments, and 30% were interviewed.

Interview Procedure and Operationalization of Measures

Each participant completed a 2 1/2 hour, face-to-face in-depth interview that included both structured and open-ended questions. The first wave of interviews were conducted between March 1989 and September 1990. Prior to signing informed consents, participants were told that the interview would include questions about childhood family relationships, childhood sexual experiences, parental alcohol and drug use, current family, relationship with

spouse/partner, and her own and her partner's alcohol and drug use. Respondents also consented to have the interview tape-recorded. All respondents agreed to continue with the taping of the interview.

Previous research has shown that multiple questions of a specific nature produce more reports of sexual abuse than single, more general questions (Peters, Wyatt, & Finkelhor, 1986). Therefore, the interview questions on sexual abuse were generated from the list of questions created by Finkelhor (1979) and supplemented with questions developed by Sgroi (1982). Criteria were established for defining sexual abuse experiences and perpetrators. Sexual abuse was defined by a range of sexual experiences including: suggestion to do something sexual, sexually oriented touching (e.g., of breast, abdomen, thighs), masturbation ("other person touched your genitals"), digital penetration ("other person put finger or object into your vagina or anus"), and intercourse. The interviewer read a list of specific sexual experiences to which the respondent answered yes or no according to what she had experienced before 18. Perpetrators were defined as someone at least five years older, any relative, or someone who had initiated any of these actions against her will. For each perpetrator mentioned, the respondent was asked the perpetrator's relationship to her, both their ages at the time of the event, approximately how many times the abuse occurred, and over what length of time these events had occurred. Respondents were also asked to identify the most traumatic sexual abuse experiences and to describe the event from their perspective, including questions about types of pressures or force used, physical injuries, emotional consequences, and the awareness and responses of others regarding the sexual abuse. Questions about childhood sexual abuse were asked approximately 1/2 hour into the interview to ensure that some time

had been allowed for establishing rapport with the interviewee.

Socioeconomic status was calculated using the Hollingshead index for the respondent's family of origin. Also, number of childhood family changes (e.g., death, divorce or separation of parents, moving from one household to another, etc.) were assessed for all participants. Race and age were also assessed.

Participants also completed a series of paper-and-pencil measures of psychological adjustment. The SCL-90 (Derogatis, Lipman, & Covi, 1973), an expanded version of the Hopkins Symptom Checklist, was administered to assess general psychiatric symptomatology. The scale consists of ninety items divided into nine subscales, seven of which were used (hostility, anxiety, somatization, obsessive-compulsive, interpersonal sensitivity, depression, phobic anxiety). Items are scored on a five point scale ranging from "not at all" to "extremely". Alpha coefficients for the subscales range from .77 to .90.

Self esteem was measured using the revised version of Janis Self-Esteem Scale (Eagly, 1967). The scale consists of 20 items scored on a five point scale ranging from "very often" to "practically never". The scale measures feelings of inadequacy and focuses on self-esteem in social settings. Split half reliability of .72 has been reported (Eagly, 1967).

Post Sexual Abuse Trauma (PSAT) and dissociation were measured using the Trauma Symptom Checklist (Briere and Runtz, 1989). Items for the subscales are scored on a four point scale ranging from "never" to "very often". The PSAT, a measure of Post-Traumatic Stress Disorder specific to victims of childhood sexual abuse, includes symptoms which are thought to be characteristic outcomes of sexual abuse (e.g., fear of men, sexual problems,

flashbacks). The PSAT subscale has a reliability of .72. The dissociation subscale measures such symptoms as spacing out, dizziness, and out of body experiences. This subscale has a reliability of .75. (Briere and Runtz, 1989)

Determination of Social Support Following Disclosure

Women who had been sexually abused were asked when they first told someone about the sexual experience they were describing. We were specifically interested in responses to disclosures that occurred during childhood, when the self-concept is still relatively malleable, rather than those occurring in adulthood. Responses to disclosures that occurred before 18 were coded as to whether they were supportive or unsupportive.

Women who had disclosed their sexual abuse experience before 18 were asked who she told, how the other person responded and whether or not he or she was helpful or supportive. The other person's responses were coded as supportive, not supportive, mixed, or unclear. The responses were coded by a graduate student rater who was blind to hypotheses. In the vast majority of cases the woman was asked, and stated explicitly, whether the response she received was supportive, hence a minimal amount of interpretation was necessary. Because social support is subjective, we wished to avoid applying our judgments of what responses seemed supportive. Therefore, when it was not clear as to whether the response was supportive, those cases were coded as "unclear". In some of these cases, the woman said that she felt better after "getting it off her chest", however, there was no indication as to whether the person she told (e.g., a priest in confession) was supportive. Responses coded as "mixed" involved both supportive and unsupportive responses from others (e.g., mother was supportive, father didn't believe her).

Results

Of the 477 women, 238 (50%) had been sexually abused as children. The average age at the time of the sexual abuse incident described was 11.7 years. Sexual abuse was much more prevalent in the clinical samples than in the nonclinical samples. Sixty-eight percent of the women in alcoholism treatment, 62% of the battered women, and 63% of the women in mental health treatment reported being sexually abused as children compared to 21% in the DWI sample and 39% in the random sample.

Fifty-eight percent (n=139) of the sexually abused women had disclosed abuse before 18. In virtually all cases it was the woman herself who disclosed the abuse, however, in a very few cases someone had discovered the sexual abuse as it was going on or it was obvious from the girl's injuries that she had been raped. In 28% of the cases the woman told someone after she turned 18, often a mental health professional whom she was seeing for some other problem. Because the focus of this study was on the moderating effects of childhood social support, these women were considered not to have told. An additional 12% had never revealed childhood sexual abuse before participating in the research interview.

Of the 139 women who had revealed their abuse before 18, nearly half told their parents (47%). This included 38% who told only their parents plus 7% who told parent and peers and 9% who told parents and other adults. Thirty-one percent told peers (friends or siblings) and the remaining 14% told other adults (e.g., aunt, teacher, minister). Among women in all samples, disclosures tended to occur soon after the abuse. Of the women who told before 18, 66% of disclosures occurred immediately or within the first month following the abuse. Latency of disclosure did not vary according to sample.

Of the 139 women who told, 55 (40%) of the reactions were labelled as

supportive. Examples of supportive reactions included: telling her it wasn't her fault, holding her close, confronting the perpetrator and/or making sure the abuse never happened again. Reactions labelled as supportive by women included both socioemotional and instrumental components. The woman in the following example found her adoptive parents' attempts to alter her attributions for the abuse (from self-blame to other-blame) supportive.

> (My parents) were real supportive because they told me that it wasn't my fault and that there wasn't any reason I should feel ashamed but that he should be ashamed of himself. And all these years I felt like I did something wrong, so they helped me understand that I didn't do anything wrong.

The woman in the next example also delayed disclosing her abuse but found her parents supportive both emotionally and instrumentally when she did tell them.

> My father was right there 100% behind me, my mother also. They wished I had came to them sooner about it...I just told them I was scared about the whole thing. It was something that I wasn't expecting at all, especially with a family member. I was just afraid to come out with it. The reason that I didn't was because I didn't know how you would accept it, if you would think I was making this up. I explained the reason why I did come finally was because I was afraid it was gonna go furthe They accepted everything and told me if it ever should occur again with a family member or an outsider to come to them immediately and not hesitate before something happens... WHAT SPECIFIC THINGS THAT YOUR MOTHER OR FATHER DID WERE MOST SUPPORTIVE OR HELPFUL? The action he took by getting him (uncle who abused her) out of the house and not allowing him to come back there again. He's never been back over there since that.

Another 31% (n=43) of the reactions were labelled unsupportive. Unsupportive responses included: accusing the victim of lying, ignoring or minimizing the disclosure (which often allowed the abuse to continue), beating or otherwise punishing the victim, and focusing on one's own emotions rather than providing for the victim's needs. For example, this woman was accused of bringing the sexual abuse upon herself:

> Then when I went to go tell my stepmother she wouldn't believe me. It was so upsetting to me. She wouldn't believe that I was forced to do all that. That's why she called me a slut and all that.

Another woman, sexually abused by her father, describes how others refused to believe that she was being abused, making her feel that she was crazy or somehow to blame:

> I knew I was different. I knew that what was happening to me wasn't happening to a lot of other girls and I knew it was something bad. I knew it was something that, when I told people I always got these really weird looks and like "Oh, no, not your daddy, he is so prestigious blah, blah, blah." So I was told that I was emotionally disturbed and I was crazy. So of course I said "Well, maybe I am or maybe I am doing something to invite it." I remember feeling like that a lot.

In the next case, the victim's mother believed her allegations of sexual abuse, but by not focusing on the victim's needs, her reaction was still harmful rather than helpful.

> She was no help at all. She just got sick. She went into shock...Nobody said anything to make me feel better. They all went off into their own tantrum and upsetness. Everybody kind of forgot about me.

In 12% (n=16) of the cases, support was mixed, as shown in the following example. Following a rape by her stepfather, this woman received support from her grandfather and his sister, however, her mother refused to believe her.

> (Great aunt) was crying and she was mad because she couldn't go over there and do nothing about it herself. She told me to take a bath and soak in some hot water. Then they took me to the hospital. My grandfather told my mother. She said I was lying, it didn't happen, that he didn't rape me and that I was probably doing something playing where I had no business. And that I was mad because he had whooped me earlier for the dollar, that's why I was saying that. Then my granddaddy said "then what happened to her leg?" She said "I told you she was just playing somewhere. He didn't rape her. What would he want to rape her for?" My grandfather said "Well, I'm gonna call the police." The police didn't do anything 'cause my mother wouldn't press charges.

Reactions that involved mixed support, as well as those that were unclear as to whether they were supportive (16%), could not be fit into the supportive, nonsupportive, or not told categories. Because type of support could not be discerned from these cases, they were not included in analyses examining the impact of social support on adult adjustment.

Clinical versus Nonclinical Samples

Women who have been sexually abused constitute a diverse group. Nonetheless, women in clinical samples were much more likely than women in non-clinical samples to have been sexually abused. It seemed likely that clinical women (alcoholic, battered, mental health treatment) would also differ significantly from women in the nonclinical samples (random, DWI) on demographics, adult adjustment measures, and other important variables as well, even among those who were not sexually abused. A series of t-tests comparing nonabused clinical women with nonabused nonclinical women revealed that self-esteem was significantly lower among nonabused clinical women compared to nonabused nonclinical women (3.26 vs. 3.07, $p<.01$) while scores on Post Sexual Abuse Trauma (PSAT) (.77 vs. .33, $p<.01$), Hopkins Symptom Checklist (SCL-90) (.93 vs. .46, $p<.01$) and Dissociation (.53 vs. .26, $p<.01$) were significantly higher in the clinical sample. Further, women in clinical and non-clinical samples differed substantially not only in rates of sexual abuse but also in such important areas as the percentage who were physically abused by one or both parents (50% vs. 30%, ChiSq=9.73, $p<.01$), percentage with an alcoholic parent (57%% vs. 42%, ChiSq=5.19, $p<.03$), and on the percentage of nonwhite women (39% vs. 13%, ChiSq=21.11, $p<.01$).

Because of these substantial differences, the impact of social support and sexual abuse might be masked by the inclusion of these two very different groups of women in the same analyses. Therefore, the impact of social support on adult adjustment was examined separately for clinical and nonclinical women.

Impact of Social Support on Adjustment Following Childhood Sexual Abuse

First, to examine the hypothesis that social support following a negative

event has a buffering effect, women in the clinical samples who had received social support were compared to women in the clinical samples who had not been abused. Then, women who had been sexually abused but had not received social support (didn't tell and unsupported groups) were compared to the nonabused group. The same comparisons were then performed for women in the nonclinical samples. Evidence that social support has a buffering effect would be indicated by adjustment scores among the sexually abused but supported group that are comparable to those of the non-abused group and scores in the unsupported group that are significantly worse.

As shown in Table 1, women in the clinical samples who had been sexually abused and received social support did not differ from clinical women who had not been abused on the revised Janis Self-Esteem Scale. The two groups did however differ on the SCL-90, PSAT, and Dissociation measures. Clinical women who had been abused and did not receive social support differed significantly from the not abused group on all adjustment measures. This pattern of results suggests that sexual abuse had a negative impact on the adult adjustment of clinical women but provides limited evidence for the buffering function of social support.

Insert Table 1 About Here

For nonclinical women, however, the pattern of findings supported the hypothesis that social support following a negative event has a buffering effect. Nonclinical women who had been abused but received social support did not differ from the nonabused nonclinical sample on any of the adjustment measures except for dissociation which was in the direction opposite to that

predicted. Further lending support to the buffering hypothesis was the pattern of differences between the abused sample who did not receive social support and the nonabused nonclinical sample. Nonclinical women who had been sexually abused and had experienced unsupportive reactions showed lower self-esteem and higher scores on the SCL-90, PSAT, and dissociation compared to nonabused nonclinical women.

Next, a series of ANOVAs comparing women who told and received support, women who told and did not receive support, and women who didn't tell were performed on the adjustment measures first for women in the clinical samples, then for women in the nonclinical samples. These means are presented in Table 2. Among women in the clinical samples, there was no support for the hypothesis that social support facilitates adjustment as there were no significant differences among groups on any of the adjustment measures.

Insert Table 2 About Here

A different pattern emerged among women in the nonclinical samples, however. The F tests revealed significant differences on all four of the critical dependent measures, as predicted. Post-hoc tests were then performed comparing the supported group first to the unsupported group and then to the didn't tell group. Nonclinical women who received support exhibited significantly higher self-esteem and lower scores on PSAT, Dissociation, and the SCL-90 compared to women who found others unsupportive. Nonclinical women who received support also differed significantly on all measures from women who had been sexually abused but didn't tell.

Other variables that are confounded with type of support received may

account for the pattern of results among the nonclinical abused women. For example, women who received positive social support may have suffered less severe sexual abuse, or came from more stable, more functional families. In order to examine these possibilities, sexually abused nonclinical women who received support, did not receive support, and didn't tell were compared on number of sexual abuse experiences, percentage who had experienced penetration, percentage who had experienced abuse from a father or father figure, number of childhood family changes, presence of an alcoholic parent, experiences of parental physical abuse, race, and childhood socioeconomic status. There were no significant differences among the samples on any of these measures thus bolstering confidence that it is social support that accounts for the pattern of findings.

Discussion

The study demonstrates that the supportiveness of others' responses to childhood sexual abuse can have a significant impact on the psychological adjustment of women who have been sexually abused as children. Consistent with the buffering hypothesis, nonclinical women who had been abused but had received social support could not be distinguished from nonclinical women who had not been abused on measures of adult adjustment. In contrast, nonclinical women who had been sexually abused but did not tell or told and found others unsupportive showed poorer adjustment than either women who had received support following sexual abuse or women who had not been abused. These findings suggest that encouraging children to disclose sexual abuse, as is advocated in current in-school intervention programs, is not enough to prevent negative consequences from sexual abuse. Rather, parents, other adults, and certainly professionals must be trained to handle the disclosures in a

supportive way.

This study also indicates that the impact of social support following disclosure of childhood sexual abuse on long-term adjustment depends upon the type of woman involved. Among women currently in treatment for alcoholism, family violence, or general mental health issues, the responses of others to disclosure of sexual abuse, whether supportive or unsupportive, did not appear to have an effect on current psychological functioning. Experiences of childhood sexual abuse did appear to have a lasting negative impact on adult adjustment, however. One possible explanation for these findings is that the social support intervention was simply too weak to have a lasting impact on adult psychological functioning for women who have experienced so many stressors as children and as adults.

An alternative possibility is that social support may have been protective at one point but its impact has faded over time, perhaps because of intervening stressors (e.g., substance abuse, battering spouse). Adjustment scores of clinical women may be reflecting their current distress and hence masking the impact of childhood intervention. With the exception of the Janis Self-Esteem Scale, the other measures ask women to describe symptoms they have experienced in the last two months, a time that is likely to have been very stressful for these women. Consistent with this argument is the finding that self-esteem, presumably the most stable of the measures, did not differ between the positive support group and the nonabused clinical group, but was significantly lower in the no support group. This pattern of findings is consistent with hypotheses and with the pattern for the nonclinical group. Women who participated in this study are being re-interviewed 18 months after their original interview. Self-report data collected at that later date, when

many of the clinical women are likely to have completed their treatment, will indicate whether this pattern of results is stable over time.

While this study is an important first step in demonstrating empirically the impact of social support on adjustment following childhood sexual abuse, it is not without limitations. First, data on reactions to disclosure were retrospective, with the average length of recall approximately 20 years. While such a traumatic event is likely to remain vivid over the years, forgetting and distortions are bound to occur and may in fact have occurred differentially for different groups of women. For example, women in treatment who are focusing on negative aspects of their childhoods may be more likely to recall negative as opposed to positive reactions.

Second, the length of time between abuse and disclosure of abuse varied considerably. Given limitations of sample size, all women who told before 18 were considered together. However, considerable psychic trauma may have occurred in between abuse at an earlier age and disclosure as a teenager, thus obscuring the pattern of findings.

Third, we classified a response as supportive or unsupportive according to the woman's perspective of what was supportive to her. Future studies concerned with the mechanisms by which social support influences adjustment should consider the different aspects of support (e.g.,support intended to change attributions for the event versus instrumental aid). Additional knowledge about what is and is not supportive for victims of childhood sexual abuse would allow for the development of more effective intervention programs. All of these limitations point to the importance of collecting more specific data on social support closer to the actual time of the intervention, ideally, a prospective study.

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TABLE 1

Impact of Social Support and Childhood Sexual Abuse on Adult Adjustment Clinical and Nonclinical Samples

	CLINICAL SAMPLES		
	Abused - Support (n=39)	Abused-No Support (n=105)	Not Abused (n=96)
Self-esteem	3.30	3.03*	3.26
Global SCL-90	1.40*	1.30*	.93
PSAT	1.43*	1.27*	.77
Dissociation	1.01*	.91*	.53

	NONCLINICAL SAMPLES		
	Abused - Support (N=16)	Abused-No Support (N=33)	Not Abused (N=142)
Self-esteem	4.10	3.37*	3.87
Global SCL-90	.33	.87*	.46
PSAT	.35	.74*	.33
Dissociation	.11*	.57*	.25

*Indicates that mean differs from mean for not abused group at $p<.01$ level or greater.

TABLE 2

Impact of Social Support Following Childhood Sexual Abuse on Adult Adjustment Clinical and Nonclinical Samples

	CLINICAL SAMPLES			
	Told-Positive Support (n=39)	Told-Negative Support (n=34)	Did not Tell (n=71)	F ratio
Self-esteem	3.30	3.02	3.03	NS
Global SCL-90	1.40	1.35	1.27	NS
PSAT	1.43	1.19	1.31	NS
Dissociation	1.01	.92	.90	NS

	NONCLINICAL SAMPLES			
	Told-Positive Support (n=16)	Told-Negative Support (n=9)	Did not Tell (n=24)	F ratio
Self-esteem	4.10^{a}	3.21^{b}	3.43^{ab}	F (2,46)= 3.33, p<.05
Global SCL-90	$.33^{a}$	1.09^{b}	$.79^{b}$	F (2,46)= 7.58, p<.01
PSAT	$.35^{a}$	1.02^{b}	$.64^{b}$	F (2,46)= 5.60, p<.01
Dissociation	$.11^{a}$	$.67^{b}$	$.53^{b}$	F (2,46)= 4.78, p <.02

Means with different subscripts differ at the p<.06 level or greater